

EMKEY ARTHRITIS AND OSTEOPOROSIS CLINIC

1200 Broadcasting Rd, Suite 200, Wyomissing, PA 19610
P- 610 374-8133 F- 610 375-1206

Welcome to our new patients!

On behalf of the providers and staff at Emkey Arthritis & Osteoporosis Clinic, we would like to welcome you to our practice! We are honored that you have chosen the Emkey Arthritis team to take part in your medical care.

Our Mission –

**Excellence in medical care and clinical research ensuring compassion
and the highest quality of life for each and every patient.**

Please read the following which will provide our team with the essential information needed to give you the best care possible.

- 1) Please complete all the forms in this new patient packet and bring them with you to your first visit.
- 2) You will also need to bring the following items with you for your appointment:
 - ⇒ Your photo ID
 - ⇒ All insurance cards
 - ⇒ If your insurance company requires a referral (paper or electronic) please be sure to get one from your primary care physician prior to your appointment.
 - ⇒ All pharmacy cards
 - ⇒ A current list of all medications/supplements that you take, with dosages.

Please arrive 20 MINUTES prior to your scheduled appointment so our team may register you.

Your appointment is scheduled for _____ with _____.

It is important that your referring physician supplies us with all pertinent records so that your time at your visit can be used to your best advantage. Please call your physician to ensure your records have been sent to us.

If you have any questions, please call our office at 610-374-8133.

Our automated phone reminder service will come up on your caller ID as “610-795-9206”. It’s helpful to save this number in your contacts so that you recognize the automated appointment reminders.

We are so looking forward to meeting you!

Sincerely,

The Team at Emkey Arthritis & Osteoporosis Clinic, PC

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Directions from Allentown:

Merge onto US-22 West. Merge onto US-222 South towards Lancaster. Take the Broadcasting Road exit. Turn right onto Broadcasting Road. Follow Broadcasting Road. Cross over Papermill Road. Pass the Corporate Campus entrance and both ponds on your right. Turn right onto Meridian Blvd. Take the first right onto Commerce. The parking lot will be on your left.

Directions from Harrisburg:

PA Turnpike East to exit 286 to Reading then follow directions from Pottstown below.

Directions from Pottstown/Philadelphia:

From the turnpike merge onto Morgantown Expressway /I-76 North via exit 298 toward Reading. Merge onto US-422 West via exit 118 on the left toward Reading. Merge onto US-222 North via the exit on the left toward Allentown. Take the Broadcasting Road exit, turn left onto Broadcasting Road. Continue on Broadcasting Road. Cross over Papermill Road. Pass the Corporate Campus entrance and both ponds on your right. Turn right onto Meridian Blvd. Take the first right onto Commerce. The parking lot will be on your left.

Directions from Ephrata/Lancaster:

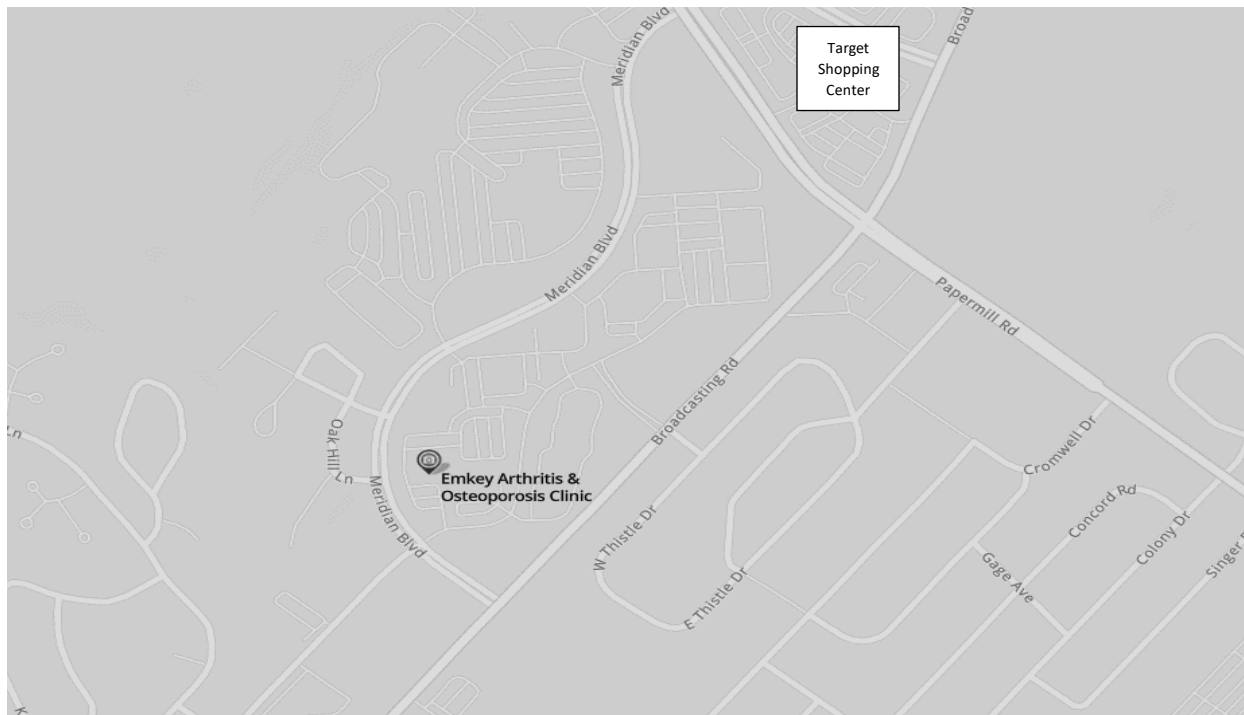
Merge onto US-30 East/US 222 toward US 222 North. Bearing right towards Allentown. Take the Broadcasting Road exit. Turn left onto Broadcasting Road. Continue on Broadcasting Road. Cross over Papermill Road. Pass the Corporate Campus entrance and both ponds on your right. Turn right onto Meridian Blvd. Take the first right onto Commerce. The parking lot will be on your left.

Directions from Wernersville:

Take Penn Ave to 422 East. Merge onto US-222 via the exit on the left toward Allentown. Take the Broadcasting Road exit. Turn left onto Broadcasting Road. Continue on Broadcasting Road. Pass over Papermill Road. Pass the Corporate Campus entrance and both ponds on your right. Turn right onto Meridian Blvd. Take the first right onto Commerce. The parking lot will be on your left.

Directions from Route 12/Warren Street Bypass:

Exit onto Papermill Road. Turn left onto Broadcasting Road. Pass the Corporate Campus entrance and both ponds on your right. Turn right onto Meridian Blvd. Take the first right onto Commerce. The parking lot will be on your left.





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CONSENT TO TREATMENT

Patient Name _____ **Date of Birth** _____

Authorization for Medical Treatment

I voluntarily consent to and authorize the physicians, nurse practitioners, physician assistants, nurses, medical assistants, and other healthcare personnel affiliated with Emkey Arthritis and Osteoporosis Clinic ("EAOC") to provide medical care, treatment, diagnostic procedures, examinations, laboratory testing, injections, infusions, and other healthcare services deemed necessary for my diagnosis and treatment.

I understand that the practice of medicine is not an exact science and that no guarantees or assurances have been made regarding the results of my care or treatment.

Release of Information for Treatment, Payment, and Healthcare Operations

I authorize EAOC to use and disclose my protected health information as necessary for:

- Medical treatment and coordination of care
- Insurance verification and claims processing
- Payment activities
- Healthcare operations as permitted by applicable law

Assignment of Insurance Benefits

I authorize payment of medical benefits directly to Emkey Arthritis and Osteoporosis Clinic for services rendered.

I understand that I am financially responsible for any charges not covered by my insurance carrier, including deductibles, copayments, coinsurance amounts, and non-covered services.



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Consent for Routine Communications

I authorize EAOC to communicate with me regarding appointments, treatment recommendations, test results, prescription information, billing matters, and other healthcare-related information via:

☐ Phone Call ☐ Voicemail ☐ Text Message ☐ Email ☐ Patient Portal

Telehealth Services (If Applicable)

I understand that some services may be provided through telehealth or other electronic communication methods when appropriate and available.

I acknowledge that:

- Telehealth may involve the electronic transmission of my health information.
- Reasonable efforts will be made to protect my privacy.
- I may refuse telehealth services and request an in-person appointment when appropriate.

Initials: _____

Acknowledgment

I certify that I have read and understand this Consent to Treat. I have had the opportunity to ask questions regarding my treatment and the policies of the practice. I understand that I may revoke certain authorizations in writing as permitted by law.

By signing below, I voluntarily consent to treatment and healthcare services provided by Emkey Arthritis and Osteoporosis Clinic.

Patient Name (Print): _____

Patient Signature: _____



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Date: _____

If Patient is a Minor or Unable to Sign:

Parent/Guardian/Personal Representative Name:

Relationship to Patient: _____

Signature: _____

Date: _____



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Privacy Statement

How we collect information about you: Emkey Arthritis and Osteoporosis Clinic (EAOC) and its employees, contractors, and volunteers may collect information through various methods, including letters, telephone conversations, emails, voicemails, patient forms, registration documents, medical records, and applications required by law or necessary to process requests for services.

What we do NOT do with your information: Information regarding your financial situation, medical condition, treatment, and healthcare services that you provide to us, whether in writing, electronically, by telephone, through voicemail, or through any application or form, is held in the strictest confidence.

EAOC does not sell, rent, trade, barter, or otherwise disclose confidential patient information to any unauthorized individual or organization. We only use and disclose protected health information as permitted or required by applicable laws, including HIPAA and other federal or state privacy regulations.

How we use your information: We use your information only as reasonably necessary to provide healthcare services, process claims, coordinate care, and conduct healthcare operations. This may include communicating with:

- Healthcare providers
- Pharmacies
- Medical equipment and supply vendors
- Insurance companies
- Laboratories
- Other entities involved in your treatment, payment, or healthcare operations

Such communications may be necessary to:

- Verify the accuracy of your medical information
- Determine eligibility for services or benefits
- Obtain medical supplies, devices, medications, or treatments
- Process insurance claims and authorizations
- Coordinate and manage your healthcare



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If information is submitted with the intent to commit fraud, or if fraudulent activity is reasonably suspected, EAOE may disclose information to law enforcement agencies, regulatory authorities, courts, attorneys, or other entities as permitted or required by law.

Information we do NOT collect: Our website does not use cookies for tracking visitors. We do not collect personally identifiable information from website visitors unless voluntarily provided through a contact form, email, or other direct communication.

The website may utilize third-party links or services that operate independently from EAOE. These third parties may collect information according to their own privacy practices. We encourage visitors to review the privacy policies of any external websites they access.

Limited Use of Non-Identifying Information: EAOE may use non-identifying patient information, testimonials, thank-you notes, stories, or other communications for educational, fundraising, or promotional purposes that support our mission.

No identifying information, including photographs, names, addresses, telephone numbers, email addresses, or other personally identifiable information, will be used without the patient's prior written authorization when required by law.

Patients will not receive compensation for the use of authorized materials.

You may request in writing that your information not be used for promotional purposes. EAOE will honor all applicable privacy preferences and legal requirements regarding the use of your information.

Questions About Privacy: If you have questions regarding this Notice of Information Practices and Privacy Statement or your privacy rights, please contact EAOE directly.



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By signing below, I acknowledge that I have read, fully understand, and have been offered a copy of Emkey Arthritis and Osteoporosis Clinic's Privacy Statement.

Patient Name: _____ Patient Date of Birth: _____

Patient Signature: _____

Date of signature: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our Uses and Disclosures of Your Health Information

We may use and disclose your health information for treatment, payment, and healthcare operations. This includes communicating with healthcare providers, pharmacies, laboratories, and insurance companies as necessary to provide care.

Other Permitted Disclosures

We may disclose information as required by law, for public health activities, health oversight activities, judicial proceedings, law enforcement purposes, workers compensation claims, and to prevent serious threats to health or safety.

Uses Requiring Authorization



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Uses and disclosures not otherwise described in this notice will be made only with your written authorization. You may revoke an authorization in writing at any time.

Your Rights

You have the right to inspect and obtain copies of your records, request amendments, request restrictions, request confidential communications, receive an accounting of disclosures, obtain a paper copy of this notice, and receive breach notifications when required by law.

Our Responsibilities

EAOC is required by law to maintain the privacy and security of protected health information, provide this notice, and follow the privacy practices described herein.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with EAOC or the U.S. Department of Health and Human Services. You will not be retaliated against for filing a complaint.

I acknowledge that I have read, fully understand, and have been offered a copy of Emkey Arthritis and Osteoporosis Clinic's HIPAA Notice of Privacy Practices.

If we cannot reach you or in case of emergency, please list below who we contact regarding your medical information and care:

Permission to leave detailed medical information message on: Home # _____ Cell # _____ Work # _____		
Permission to speak with the following person(s) re: any portion of your medical information		
Name _____	Relationship _____	phone# _____



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Name _____	Relationship _____	phone# _____
Name _____	Relationship _____	phone# _____

Patient Name: _____ Patient Date of Birth: _____

Patient Signature: _____

Date of signature: _____

If signed by personal representative:

Representative Name: _____

Relationship to Patient: _____

Date: _____



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FINANCIAL POLICY

Thank you for allowing the team at Emkey Arthritis & Osteoporosis Clinic to be part of your health care. We are honored and dedicated to providing you with the best possible care. We ask that you read the following policies and sign acknowledgement below.

Please be sure to bring your medical insurance card(s) to each visit.

Referrals / Authorizations: Since we are a specialist practice, your healthcare policy may require a referral from your primary care physician. If this is the case, please obtain your referral and bring it to your appointment. If a referral cannot be obtained, we may have to cancel and reschedule your appointment until one has been issued. While our staff will assist in obtaining prior authorizations when required, authorization does not guarantee payment or coverage by your insurance carrier.

Insurance Information Responsibility: Patients are responsible for providing current and accurate insurance information at each visit. Failure to provide updated insurance information may result in the patient being responsible for the full balance of services rendered.

High-Deductible Plans: If you participate with a high-deductible health plan, and if your deductible has not been met, we may request payment of estimated patient responsibility at the time of service. Any overpayment or underpayment will be reconciled after insurance processing.

Out of Network Plans: It is your responsibility to understand your out-of-network benefits. Payment will be expected at the time of service and we will provide you with an invoice that you can submit to your insurance for reimbursement.

In Network Plans: We participate with many insurance plans; however, participation does not guarantee payment for all services rendered. We are expected to collect from you at the time of service any co-pays, deductibles and out-of-pocket portions. For your convenience, we accept payment by cash, check, or credit card. Please be prepared to pay at your appointment. If you have any questions as to what your responsibility would be, you may contact your insurance.

Self-Pay Patients: Patients without insurance coverage are expected to pay at the time of service unless prior payment arrangements have been made.

Non-Covered Services: Patients are responsible for services deemed not medically necessary or otherwise not covered by their insurance plan. This includes, but is not limited to, infusions, biologics, DEXA scans, injections, and specialty testing.

Patient Balances: We will bill you any patient coinsurance, deductible and/or member portion that your insurance states are your responsibility. Should you receive a patient statement in the mail the office expects full payment within 30 days. If you are unable to pay in full, it will be your responsibility to contact our billing office to set up an agreed upon payment arrangement. Billing office phone is 610 374-8133 option 6. If your bill goes unpaid for >90 days, non-urgent appointments will be suspended until the bill is paid.



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Credit Card on File: The practice may maintain a credit card on file for balances identified as patient responsibility after insurance processing. Patients will be notified prior to charging the card.

Returned Checks: There is a \$45.00 fee for each returned check.

***Cancellation and No-Show Appointments:** 24-hour notice is required if you need to cancel or reschedule your appointment. We have an extensive waiting list, and this allows others the opportunity to be seen. If you did not cancel 24 hours prior OR missed your appointment, there will be a fee of \$75.00 for established patients and \$125.00 for new patients charged to your account. Insurance companies do not cover missed appointment fees and these charges are the sole responsibility of the patient.

Medical Record Transfer Fees: If you are requesting your medical records, fees for medical record copies will be charged in accordance with Pennsylvania law and applicable regulations. Once payment is received, we will release records to you within 5 business days.

Additional Forms: FMLA forms \$45. Disability forms are \$45. Parking placard forms are \$25. Forms will be completed upon receipt of the payment by cash, check or credit card.

MY SIGNATURE BELOW ACKNOWLEDGES THE FOLLOWING:

- I understand that copayments, deductibles, coinsurance amounts, non-covered services, missed appointment fees, and other balances identified as my responsibility are due according to this financial policy.
- I AM RESPONSIBLE FOR ANY MEDICAL EXPENSES NOT COVERED BY MY HEALTH INSURANCE PLAN.

Print Name: _____ **Date of Birth:** _____

Signature: _____ **Date:** _____

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NEW PATIENT DEMOGRAPHIC FORM

Name: _____ Date of Birth: ____/____/____

Age: _____ Gender (circle one): Male Female

Address: _____

City: _____ Zip: _____

Home phone #: _____ Mobile phone #: _____

Email address (required for our portal): _____

Patient Work Status (Please circle one): Full-time Part-time Student Retired Other: _____

Patient's Employer: _____ Work Phone #: _____

Employer's Address: _____

Patient Marital Status (Please circle one): Single Married Divorced Separated Widowed

Spouse's Name: _____ Spouse Date of Birth: ____/____/____

Spouse's Address: _____

Spouse's Employer: _____

Emergency Contact: _____ Relationship: _____ Phone #: _____

Primary Insurance: _____

Subscriber's Name: _____ Date of Birth: ____/____/____

Relationship: _____ ID #: _____ Group #: _____

Secondary Insurance: _____

Subscriber's Name: _____ Date of Birth: ____/____/____

Relationship: _____ ID #: _____ Group #: _____

Family Physician: _____ Phone #: _____

Referring Physician: _____ Phone #: _____

Is your visit related to an open insurance claim for a car accident or workman's compensation? Yes _____ No _____

If yes, please provide the following information: Date of Injury: ____/____/____

Claim Carrier: _____ Claim ID #: _____

Claim Adjustor's Name & Phone #: _____

Description of Injury: _____

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NEW PATIENT HISTORY FORM

Name: _____ Date of Birth ____/____/____

Education: Grade School _____ High School _____ College _____ Graduate School _____

Occupation: _____ # of hours worked per week (average) _____

Referred by (check one): Self _____ Family _____ Friend _____ Doctor _____ Web _____ Other _____

Name of Referring Physician: _____

Primary Care Physician: _____

Do you have an orthopedic surgeon? Yes _____ No _____ If yes, name: _____

Briefly describe your present symptoms: _____

Date symptoms began (approximate): ____/____/____ Diagnosis: _____

Previous treatment for this problem (include physical therapy, surgery, medications, and injections): _____

Please list the name(s) of other practitioner(s) you have seen for this problem: _____

Medical History (please list all medical problems for which you have been diagnosed and treated):

_____; _____; _____; _____; _____;
_____; _____; _____; _____; _____;
_____; _____; _____; _____; _____;

Surgical History (please list all previous operations, name of hospital, reason for surgery and approximate dates):

Family History (please give any pertinent medical history of family members):

Mother _____

Father _____

Siblings _____

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NEW PATIENT HISTORY FORM cont'd

Name _____

Social History

Caffeine: Yes No Servings per day _____ Type: []Chocolate []Coffee []Energy Drinks []Soda []Tea
Alcohol: Yes No Avg # drinks ____ []Daily []Occasionally []Rarely []Socially Type: []Beer []Liquor []Wine
Tobacco Use: Yes No Previous Quit Date _____
Nicotine Vapor: Yes No If yes how long _____
Illicit Drug Use: Yes No If yes types of drugs _____
Exercise: Yes No If yes type of exercise _____

How many hours of sleep do you get a night? _____

Do you wake up feeling rested? []Yes []No

Have you had any recent falls? []Yes []No

Medications (please list ALL medicines you are currently taking, including non-prescription, vitamins and supplements):

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Allergies (please list all allergies and bad reactions to medicines and medical products):

Name of Preferred Pharmacy: _____ Phone Number: _____

Pharmacy Location: _____

When did you have your last:

PCP visit: _____ DEXA scan: _____ Mammogram: _____

Visual field exam: _____ TB/PPD test: _____ Flu vaccine: _____

Pneumonia vaccine(s): Pneumo-Vax (primary) _____ Prevnar 13 (booster) _____

COVID-19 Vaccine:

Manufacturer: Moderna _____ Pfizer _____ Johnson & Johnson _____

Primary Vaccine: 1st Vaccine Date _____ 2nd Vaccine Date _____

Booster: _____ / _____ / _____ / _____
1ST 2ND 3RD 4TH

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Name/Nombre _____ Date/Fecha _____

FOR WOMAN ONLY/SOLO PARA MUJER